

SENATE AMENDMENTS

2nd Printing

By: Bonnen of Galveston, Guillen

H.B. No. 2327

A BILL TO BE ENTITLED

AN ACT

relating to preauthorization of certain medical care and health care services by certain health benefit plan issuers and to the regulation of utilization review, independent review, and peer review for health benefit plan and workers' compensation coverage.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

ARTICLE 1. PREAUTHORIZATION

SECTION 1.01. Section 843.348(b), Insurance Code, is amended to read as follows:

(b) A health maintenance organization that uses a preauthorization process for health care services shall provide each participating physician or provider, not later than the fifth ~~10th~~ business day after the date a request is made, a list of health care services that ~~do not~~ require preauthorization and information concerning the preauthorization process.

SECTION 1.02. Subchapter J, Chapter 843, Insurance Code, is amended by adding Sections 843.3481, 843.3482, 843.3483, and 843.3484 to read as follows:

Sec. 843.3481. POSTING OF PREAUTHORIZATION REQUIREMENTS.

(a) A health maintenance organization that uses a preauthorization process for health care services shall make the requirements and information about the preauthorization process readily accessible to enrollees, physicians, providers, and the general public by posting the requirements and information on the health maintenance

1 organization's Internet website.

2 (b) The preauthorization requirements and information
3 described by Subsection (a) must:

4 (1) be posted:

5 (A) conspicuously in a location on the Internet
6 website that does not require the use of a log-in or other input of
7 personal information to view the information; and

8 (B) in a format that is easily searchable and
9 accessible;

10 (2) be written in plain language that is easily
11 understandable by enrollees, physicians, providers, and the
12 general public;

13 (3) include a detailed description of the
14 preauthorization process and procedure; and

15 (4) include an accurate and current list of the health
16 care services for which the health maintenance organization
17 requires preauthorization that includes the following information
18 specific to each service:

19 (A) the effective date of the preauthorization
20 requirement;

21 (B) a list or description of any supporting
22 documentation that the health maintenance organization requires
23 from the physician or provider ordering or requesting the service
24 to approve a request for that service;

25 (C) the applicable screening criteria using
26 Current Procedural Terminology codes and International
27 Classification of Diseases codes; and

1 (D) statistics regarding preauthorization
2 approval and denial rates for the service in the preceding year and
3 for each previous year the preauthorization requirement was in
4 effect, including statistics in the following categories:

5 (i) physician or provider type and
6 specialty, if any;

7 (ii) indication offered;

8 (iii) reasons for request denial;

9 (iv) denials overturned on internal appeal;

10 (v) denials overturned on external appeal;

11 and

12 (vi) total annual preauthorization
13 requests, approvals, and denials for the service.

14 Sec. 843.3482. CHANGES TO PREAUTHORIZATION REQUIREMENTS.

15 (a) Except as provided by Subsection (b), not later than the 60th
16 day before the date a new or amended preauthorization requirement
17 takes effect, a health maintenance organization that uses a
18 preauthorization process for health care services shall provide
19 each participating physician or provider written notice of the new
20 or amended preauthorization requirement and disclose the new or
21 amended requirement in the health maintenance organization's
22 newsletter or network bulletin, if any.

23 (b) For a change in a preauthorization requirement or
24 process that removes a service from the list of health care services
25 requiring preauthorization or amends a preauthorization
26 requirement in a way that is less burdensome to enrollees or
27 participating physicians or providers, a health maintenance

1 organization shall provide each participating physician or
2 provider written notice of the change in the preauthorization
3 requirement and disclose the change in the health maintenance
4 organization's newsletter or network bulletin, if any, not later
5 than the fifth day before the date the change takes effect.

6 (c) Not later than the fifth day before the date a new or
7 amended preauthorization requirement takes effect, a health
8 maintenance organization shall update its Internet website to
9 disclose the change to the health maintenance organization's
10 preauthorization requirements or process and the date and time the
11 change is effective.

12 Sec. 843.3483. REMEDY FOR NONCOMPLIANCE; AUTOMATIC WAIVER.
13 In addition to any other penalty or remedy provided by law, a health
14 maintenance organization that uses a preauthorization process for
15 health care services that violates this subchapter with respect to
16 a required publication, notice, or response regarding its
17 preauthorization requirements, including by failing to comply with
18 any applicable deadline for the publication, notice, or response,
19 waives the health maintenance organization's preauthorization
20 requirements with respect to any health care service affected by
21 the violation, and any health care service affected by the
22 violation is considered preauthorized by the health maintenance
23 organization.

24 Sec. 843.3484. EFFECT OF PREAUTHORIZATION WAIVER. A waiver
25 of preauthorization requirements under Section 843.3483 may not be
26 construed to:

27 (1) authorize a physician or provider to provide

1 health care services outside of the physician's or provider's
2 applicable scope of practice as defined by state law; or

3 (2) require the health maintenance organization to pay
4 for a health care service provided outside of the physician's or
5 provider's applicable scope of practice as defined by state law.

6 SECTION 1.03. Section 1301.135(a), Insurance Code, is
7 amended to read as follows:

8 (a) An insurer that uses a preauthorization process for
9 medical care or ~~[and]~~ health care services shall provide to each
10 preferred provider, not later than the fifth ~~[10th]~~ business day
11 after the date a request is made, a list of medical care and health
12 care services that require preauthorization and information
13 concerning the preauthorization process.

14 SECTION 1.04. Subchapter C-1, Chapter 1301, Insurance Code,
15 is amended by adding Sections 1301.1351, 1301.1352, 1301.1353, and
16 1301.1354 to read as follows:

17 Sec. 1301.1351. POSTING OF PREAUTHORIZATION REQUIREMENTS.

18 (a) An insurer that uses a preauthorization process for medical
19 care or health care services shall make the requirements and
20 information about the preauthorization process readily accessible
21 to insureds, physicians, health care providers, and the general
22 public by posting the requirements and information on the insurer's
23 Internet website.

24 (b) The preauthorization requirements and information
25 described by Subsection (a) must:

26 (1) be posted:

27 (A) conspicuously in a location on the Internet

website that does not require the use of a log-in or other input of personal information to view the information; and

(B) in a format that is easily searchable and accessible;

(2) be written in plain language that is easily understandable by insureds, physicians, health care providers, and the general public;

(3) include a detailed description of the preauthorization process and procedure; and

(4) include an accurate and current list of medical care and health care services for which the insurer requires preauthorization that includes the following information specific to each service:

(A) the effective date of the preauthorization requirement;

(B) a list or description of any supporting documentation that the insurer requires from the physician or health care provider ordering or requesting the service to approve a request for the service;

(C) the applicable screening criteria using Current Procedural Terminology codes and International Classification of Diseases codes; and

(D) statistics regarding the insurer's preauthorization approval and denial rates for the medical care or health care service in the preceding year and for each previous year the preauthorization requirement was in effect, including statistics in the following categories:

1 (i) physician or health care provider type
2 and specialty, if any;
3 (ii) indication offered;
4 (iii) reasons for request denial;
5 (iv) denials overturned on internal appeal;
6 (v) denials overturned on external appeal;
7 and
8 (vi) total annual preauthorization
9 requests, approvals, and denials for the service.

10 (c) The provisions of this section may not be waived,
11 voided, or nullified by contract.

12 Sec. 1301.1352. CHANGES TO PREAUTHORIZATION REQUIREMENTS.

13 (a) Except as provided by Subsection (b), not later than the 60th
14 day before the date a new or amended preauthorization requirement
15 takes effect, an insurer that uses a preauthorization process for
16 medical care or health care services shall provide to each
17 preferred provider written notice of the new or amended
18 preauthorization requirement and disclose the new or amended
19 requirement in the insurer's newsletter or network bulletin, if
20 any.

21 (b) For a change in a preauthorization requirement or
22 process that removes a service from the list of medical care or
23 health care services requiring preauthorization or amends a
24 preauthorization requirement in a way that is less burdensome to
25 insureds, physicians, or health care providers, an insurer shall
26 provide each preferred provider written notice of the change in the
27 preauthorization requirement and disclose the change in the

1 insurer's newsletter or network bulletin, if any, not later than
2 the fifth day before the date the change takes effect.

3 (c) Not later than the fifth day before the date a new or
4 amended preauthorization requirement takes effect, an insurer
5 shall update its Internet website to disclose the change to the
6 insurer's preauthorization requirements or process and the date and
7 time the change is effective.

8 (d) The provisions of this section may not be waived,
9 voided, or nullified by contract.

10 Sec. 1301.1353. REMEDY FOR NONCOMPLIANCE; AUTOMATIC
11 WAIVER. (a) In addition to any other penalty or remedy provided by
12 law, an insurer that uses a preauthorization process for medical
13 care or health care services that violates this subchapter with
14 respect to a required publication, notice, or response regarding
15 its preauthorization requirements, including by failing to comply
16 with any applicable deadline for the publication, notice, or
17 response, waives the insurer's preauthorization requirements with
18 respect to any medical care or health care service affected by the
19 violation, and any medical care or health care service affected by
20 the violation is considered preauthorized by the insurer.

21 (b) The provisions of this section may not be waived,
22 voided, or nullified by contract.

23 Sec. 1301.1354. EFFECT OF PREAUTHORIZATION WAIVER. (a) A
24 waiver of preauthorization requirements under Section 1301.1353
25 may not be construed to:

26 (1) authorize a physician or health care provider to
27 provide medical care or health care services outside of the

1 physician's or health care provider's applicable scope of practice
2 as defined by state law; or

3 (2) require the insurer to pay for a medical care or
4 health care service provided outside of the physician's or health
5 care provider's applicable scope of practice as defined by state
6 law.

7 (b) The provisions of this section may not be waived,
8 voided, or nullified by contract.

9 ARTICLE 2. UTILIZATION, INDEPENDENT, AND PEER REVIEW

10 SECTION 2.01. Section 4201.002(12), Insurance Code, is
11 amended to read as follows:

12 (12) "Provider of record" means the physician or other
13 health care provider with primary responsibility for the health
14 care~~[, treatment, and]~~ services provided to or requested on behalf
15 of an enrollee or the physician or other health care provider that
16 has provided or has been requested to provide the health care
17 services to the enrollee. The term includes a health care facility
18 where the health care services are ~~[if treatment is]~~ provided on an
19 inpatient or outpatient basis.

20 SECTION 2.02. Sections 4201.151 and 4201.152, Insurance
21 Code, are amended to read as follows:

22 Sec. 4201.151. UTILIZATION REVIEW PLAN. A utilization
23 review agent's utilization review plan, including reconsideration
24 and appeal requirements, must be reviewed by a physician licensed
25 to practice medicine in this state and conducted in accordance with
26 standards developed with input from appropriate health care
27 providers and approved by a physician licensed to practice medicine

1 in this state.

2 Sec. 4201.152. UTILIZATION REVIEW UNDER ~~[DIRECTION OF]~~
3 PHYSICIAN. A utilization review agent shall conduct utilization
4 review under the supervision and direction of a physician licensed
5 to practice medicine in this ~~[by a]~~ state ~~[licensing agency in the~~
6 ~~United States]~~.

7 SECTION 2.03. Subchapter D, Chapter 4201, Insurance Code,
8 is amended by adding Section 4201.1525 to read as follows:

9 Sec. 4201.1525. UTILIZATION REVIEW BY PHYSICIAN. (a) A
10 utilization review agent that uses a physician to conduct
11 utilization review may only use a physician licensed to practice
12 medicine in this state.

13 (b) A payor that conducts utilization review on the payor's
14 own behalf is subject to Subsection (a) as if the payor were a
15 utilization review agent.

16 SECTION 2.04. Section 4201.153(d), Insurance Code, is
17 amended to read as follows:

18 (d) Screening criteria must be used to determine only
19 whether to approve the requested treatment. Before issuing an
20 adverse determination, a utilization review agent must obtain a
21 determination of medical necessity by referring a proposed [A]
22 denial of requested treatment [must be referred] to:

23 (1) an appropriate physician, dentist, or other health
24 care provider; or

25 (2) if the treatment is requested, ordered, provided,
26 or to be provided by a physician, a physician licensed to practice
27 medicine in this state who is of the same or a similar specialty as

1 that physician [~~to determine medical necessity~~].

2 SECTION 2.05. Sections 4201.155, 4201.206, and 4201.251,
3 Insurance Code, are amended to read as follows:

4 Sec. 4201.155. LIMITATION ON NOTICE REQUIREMENTS AND REVIEW
5 PROCEDURES. (a) A utilization review agent may not establish or
6 impose a notice requirement or other review procedure that is
7 contrary to the requirements of the health insurance policy or
8 health benefit plan.

9 (b) This section may not be construed to release a health
10 insurance policy or health benefit plan from full compliance with
11 this chapter or other applicable law.

12 Sec. 4201.206. OPPORTUNITY TO DISCUSS TREATMENT BEFORE
13 ADVERSE DETERMINATION. (a) Subject to Subsection (b) and the
14 notice requirements of Subchapter G, before an adverse
15 determination is issued by a utilization review agent who questions
16 the medical necessity, the [~~or~~] appropriateness, or the
17 experimental or investigational nature[~~7~~] of a health care service,
18 the agent shall provide the health care provider who ordered,
19 requested, provided, or is to provide the service a reasonable
20 opportunity to discuss with a physician licensed to practice
21 medicine in this state the patient's treatment plan and the
22 clinical basis for the agent's determination.

23 (b) If the health care service described by Subsection (a)
24 was ordered, requested, or provided, or is to be provided by a
25 physician, the opportunity described by that subsection must be
26 with a physician licensed to practice medicine in this state who is
27 of the same or a similar specialty as that physician.

1 Sec. 4201.251. DELEGATION OF UTILIZATION REVIEW. A
2 utilization review agent may delegate utilization review to
3 qualified personnel in the hospital or other health care facility
4 in which the health care services to be reviewed were or are to be
5 provided. The delegation does not release the agent from the full
6 responsibility for compliance with this chapter or other applicable
7 law, including the conduct of those to whom utilization review has
8 been delegated.

9 SECTION 2.06. Sections 4201.252(a) and (b), Insurance Code,
10 are amended to read as follows:

11 (a) Personnel employed by or under contract with a
12 utilization review agent to perform utilization review must be
13 appropriately trained and qualified and meet the requirements of
14 this chapter and other applicable law, including licensing
15 requirements.

16 (b) Personnel, other than a physician licensed to practice
17 medicine in this state, who obtain oral or written information
18 directly from a patient's physician or other health care provider
19 regarding the patient's specific medical condition, diagnosis, or
20 treatment options or protocols must be a nurse, physician
21 assistant, or other health care provider qualified and licensed or
22 otherwise authorized by law and the appropriate licensing agency in
23 this state to provide the requested service.

24 SECTION 2.07. Section 4201.356, Insurance Code, is amended
25 to read as follows:

26 Sec. 4201.356. DECISION BY PHYSICIAN REQUIRED; SPECIALTY
27 REVIEW. (a) The procedures for appealing an adverse determination

1 must provide that a physician licensed to practice medicine in this
2 state makes the decision on the appeal, except as provided by
3 Subsection (b) or (c).

4 (b) For a health care service ordered, requested, provided,
5 or to be provided by a physician, the procedures for appealing an
6 adverse determination must provide that a physician licensed to
7 practice medicine in this state who is of the same or a similar
8 specialty as that physician makes the decision on appeal, except as
9 provided by Subsection (c).

10 (c) If not later than the 10th working day after the date an
11 appeal is denied the enrollee's health care provider states in
12 writing good cause for having a particular type of specialty
13 provider review the case, a health care provider who is of the same
14 or a similar specialty as the health care provider who would
15 typically manage the medical or dental condition, procedure, or
16 treatment under consideration for review and who is licensed or
17 otherwise authorized by the appropriate licensing agency in this
18 state to manage the medical or dental condition, procedure, or
19 treatment shall review the decision denying the appeal. The
20 specialty review must be completed within 15 working days of the
21 date the health care provider's request for specialty review is
22 received.

23 SECTION 2.08. Sections 4201.357(a), (a-1), and (a-2),
24 Insurance Code, are amended to read as follows:

25 (a) The procedures for appealing an adverse determination
26 must include, in addition to the written appeal, a procedure for an
27 expedited appeal of a denial of emergency care or a denial of

1 continued hospitalization. That procedure must include a review by
2 a health care provider who:

3 (1) has not previously reviewed the case; ~~and~~

4 (2) is of the same or a similar specialty as the health
5 care provider who would typically manage the medical or dental
6 condition, procedure, or treatment under review in the appeal; and

7 (3) for a review of a health care service:

8 (A) ordered, requested, provided, or to be
9 provided by a health care provider who is not a physician, is
10 licensed or otherwise authorized by the appropriate licensing
11 agency in this state to provide the service in this state; or

12 (B) ordered, requested, provided, or to be
13 provided by a physician, is licensed to practice medicine in this
14 state.

15 (a-1) The procedures for appealing an adverse determination
16 must include, in addition to the written appeal and the appeal
17 described by Subsection (a), a procedure for an expedited appeal of
18 a denial of prescription drugs or intravenous infusions for which
19 the patient is receiving benefits under the health insurance
20 policy. That procedure must include a review by a health care
21 provider who:

22 (1) has not previously reviewed the case; ~~and~~

23 (2) is of the same or a similar specialty as the health
24 care provider who would typically manage the medical or dental
25 condition, procedure, or treatment under review in the appeal; and

26 (3) for a review of a health care service:

27 (A) ordered, requested, provided, or to be

1 provided by a health care provider who is not a physician, is
2 licensed or otherwise authorized by the appropriate licensing
3 agency in this state to provide the service in this state; or

4 (B) ordered, requested, provided, or to be
5 provided by a physician, is licensed to practice medicine in this
6 state.

7 (a-2) An adverse determination under Section 1369.0546 is
8 entitled to an expedited appeal. The physician or, if appropriate,
9 other health care provider deciding the appeal must consider
10 atypical diagnoses and the needs of atypical patient populations.
11 The physician must be licensed to practice medicine in this state
12 and the health care provider must be licensed or otherwise
13 authorized by the appropriate licensing agency in this state.

14 SECTION 2.09. Section 4201.359, Insurance Code, is amended
15 by adding Subsection (c) to read as follows:

16 (c) A physician described by Subsection (b)(2) must comply
17 with this chapter and other applicable laws and be licensed to
18 practice medicine in this state. A health care provider described
19 by Subsection (b)(2) must comply with this chapter and other
20 applicable laws and be licensed or otherwise authorized by the
21 appropriate licensing agency in this state.

22 SECTION 2.10. Sections 4201.453 and 4201.454, Insurance
23 Code, are amended to read as follows:

24 Sec. 4201.453. UTILIZATION REVIEW PLAN. A specialty
25 utilization review agent's utilization review plan, including
26 reconsideration and appeal requirements, must be:

27 (1) reviewed by a health care provider of the

1 appropriate specialty who is licensed or otherwise authorized to
2 provide the specialty health care service in this state; and

3 (2) conducted in accordance with standards developed
4 with input from a health care provider of the appropriate specialty
5 who is licensed or otherwise authorized to provide the specialty
6 health care service in this state.

7 Sec. 4201.454. UTILIZATION REVIEW UNDER DIRECTION OF
8 PROVIDER OF SAME SPECIALTY. A specialty utilization review agent
9 shall conduct utilization review under the direction of a health
10 care provider who is of the same specialty as the agent and who is
11 licensed or otherwise authorized to provide the specialty health
12 care service in this ~~[by a] state [licensing agency in the United~~
13 ~~States]~~.

14 SECTION 2.11. Sections 4201.455(a) and (b), Insurance Code,
15 are amended to read as follows:

16 (a) Personnel who are employed by or under contract with a
17 specialty utilization review agent to perform utilization review
18 must be appropriately trained and qualified and meet the
19 requirements of this chapter and other applicable law of this
20 state, including licensing laws.

21 (b) Personnel who obtain oral or written information
22 directly from a physician or other health care provider must be a
23 nurse, physician assistant, or other health care provider of the
24 same specialty as the agent and who are licensed or otherwise
25 authorized to provide the specialty health care service in this ~~[by~~
26 ~~a] state [licensing agency in the United States]~~.

27 SECTION 2.12. Sections 4201.456 and 4201.457, Insurance

1 Code, are amended to read as follows:

2 Sec. 4201.456. OPPORTUNITY TO DISCUSS TREATMENT BEFORE
3 ADVERSE DETERMINATION. Subject to the notice requirements of
4 Subchapter G, before an adverse determination is issued by a
5 specialty utilization review agent who questions the medical
6 necessity, the ~~[or]~~ appropriateness, or the experimental or
7 investigational nature~~[r]~~ of a health care service, the agent shall
8 provide the health care provider who ordered, requested, provided,
9 or is to provide the service a reasonable opportunity to discuss the
10 patient's treatment plan and the clinical basis for the agent's
11 determination with a health care provider who is:

- 12 (1) of the same specialty as the agent; and
13 (2) licensed or otherwise authorized to provide the
14 specialty health care service in this state.

15 Sec. 4201.457. APPEAL DECISIONS. A specialty utilization
16 review agent shall comply with the requirement that a physician or
17 other health care provider who makes the decision in an appeal of an
18 adverse determination must be:

- 19 (1) of the same or a similar specialty as the health
20 care provider who would typically manage the specialty condition,
21 procedure, or treatment under review in the appeal; and
22 (2) licensed or otherwise authorized to provide the
23 health care service in this state.

24 SECTION 2.13. Section 4202.002, Insurance Code, is amended
25 by adding Subsection (b-1) to read as follows:

- 26 (b-1) The standards adopted under Subsection (b)(3) must:
27 (1) ensure that personnel conducting independent

1 review for a health care service are licensed or otherwise
2 authorized to provide the same or a similar health care service in
3 this state; and

4 (2) be consistent with the licensing laws of this
5 state.

6 SECTION 2.14. Section 408.0043, Labor Code, is amended by
7 adding Subsection (c) to read as follows:

8 (c) Notwithstanding Subsection (b), if a health care
9 service is requested, ordered, provided, or to be provided by a
10 physician, a person described by Subsection (a)(1), (2), or (3) who
11 reviews the service with respect to a specific workers'
12 compensation case must be of the same or a similar specialty as that
13 physician.

14 SECTION 2.15. Subchapter B, Chapter 151, Occupations Code,
15 is amended by adding Section 151.057 to read as follows:

16 Sec. 151.057. APPLICATION TO UTILIZATION REVIEW. (a) In
17 this section:

18 (1) "Adverse determination" means a determination
19 that health care services provided or proposed to be provided to an
20 individual in this state by a physician or at the request or order
21 of a physician are not medically necessary or are experimental or
22 investigational.

23 (2) "Payor" has the meaning assigned by Section
24 4201.002, Insurance Code.

25 (3) "Utilization review" has the meaning assigned by
26 Section 4201.002, Insurance Code, and the term includes a review
27 of:

1 (A) a step therapy protocol exception request
2 under Section 1369.0546, Insurance Code; and

3 (B) prescription drug benefits under Section
4 1369.056, Insurance Code.

5 (4) "Utilization review agent" means:

6 (A) an entity that conducts utilization review
7 under Chapter 4201, Insurance Code;

8 (B) a payor that conducts utilization review on
9 the payor's own behalf or on behalf of another person or entity;

10 (C) an independent review organization certified
11 under Chapter 4202, Insurance Code; or

12 (D) a workers' compensation health care network
13 certified under Chapter 1305, Insurance Code.

14 (b) A person who does the following is considered to be
15 engaged in the practice of medicine in this state and is subject to
16 appropriate regulation by the board:

17 (1) makes on behalf of a utilization review agent or
18 directs a utilization review agent to make an adverse
19 determination, including:

20 (A) an adverse determination made on
21 reconsideration of a previous adverse determination;

22 (B) an adverse determination in an independent
23 review under Subchapter I, Chapter 4201, Insurance Code;

24 (C) a refusal to provide benefits for a
25 prescription drug under Section 1369.056, Insurance Code; or

26 (D) a denial of a step therapy protocol exception
27 request under Section 1369.0546, Insurance Code;

1 (2) serves as a medical director of an independent
2 review organization certified under Chapter 4202, Insurance Code;

3 (3) reviews or approves a utilization review plan
4 under Section 4201.151, Insurance Code;

5 (4) supervises and directs utilization review under
6 Section 4201.152, Insurance Code; or

7 (5) discusses a patient's treatment plan and the
8 clinical basis for an adverse determination before the adverse
9 determination is issued, as provided by Section 4201.206, Insurance
10 Code.

11 (c) For purposes of Subsection (b), a denial of health care
12 services based on the failure to request prospective or concurrent
13 review is not considered an adverse determination.

14 SECTION 2.16. Section 1305.351(d), Insurance Code, is
15 amended to read as follows:

16 (d) A [~~Notwithstanding Section 4201.152, a~~] utilization
17 review agent or an insurance carrier that uses doctors to perform
18 reviews of health care services provided under this chapter,
19 including utilization review, or peer reviews under Section
20 408.0231(g), Labor Code, may only use doctors licensed to practice
21 in this state.

22 SECTION 2.17. Section 1305.355(d), Insurance Code, is
23 amended to read as follows:

24 (d) The department shall assign the review request to an
25 independent review organization. An [~~Notwithstanding Section~~
26 ~~4202.002, an~~] independent review organization that uses doctors to
27 perform reviews of health care services under this chapter may only

1 use doctors licensed to practice in this state.

2 SECTION 2.18. Section 408.023(h), Labor Code, is amended to
3 read as follows:

4 (h) A [~~Notwithstanding Section 4201.152, Insurance Code, a~~
5 utilization review agent or an insurance carrier that uses doctors
6 to perform reviews of health care services provided under this
7 subtitle, including utilization review, may only use doctors
8 licensed to practice in this state.

9 SECTION 2.19. Section 413.031(e-2), Labor Code, is amended
10 to read as follows:

11 (e-2) An [~~Notwithstanding Section 4202.002, Insurance Code,~~
12 ~~an~~] independent review organization that uses doctors to perform
13 reviews of health care services provided under this title may only
14 use doctors licensed to practice in this state.

15 ARTICLE 3. TRANSITIONS; EFFECTIVE DATE

16 SECTION 3.01. The changes in law made by Article 1 of this
17 Act apply only to a request for preauthorization of medical care or
18 health care services made on or after January 1, 2020, under a
19 health benefit plan delivered, issued for delivery, or renewed on
20 or after that date. A request for preauthorization of medical care
21 or health care services made before January 1, 2020, or on or after
22 January 1, 2020, under a health benefit plan delivered, issued for
23 delivery, or renewed before that date is governed by the law as it
24 existed immediately before the effective date of this Act, and that
25 law is continued in effect for that purpose.

26 SECTION 3.02. The changes in law made by Article 2 of this
27 Act apply only to utilization, independent, or peer review

1 requested on or after the effective date of this Act. Utilization,
2 independent, or peer review requested before the effective date of
3 this Act is governed by the law as it existed immediately before the
4 effective date of this Act, and that law is continued in effect for
5 that purpose.

6 SECTION 3.03. This Act takes effect September 1, 2019.

ADOPTED

MAY 22 2019

Letay Spaul
Secretary of the Senate

By: Buckingham

H.B. No. 2327

Substitute the following for H.B. No. 2327:

By: Robert Lee Nichols

C.S.H.B. No. 2327

A BILL TO BE ENTITLED

1 AN ACT

2 relating to preauthorization of certain medical care and health
3 care services by certain health benefit plan issuers and to the
4 regulation of utilization review, independent review, and peer
5 review for health benefit plan and workers' compensation coverage.

6 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

7 ARTICLE 1. PREAUTHORIZATION

8 SECTION 1.01. Section 843.348(b), Insurance Code, is
9 amended to read as follows:

10 (b) A health maintenance organization that uses a
11 preauthorization process for health care services shall provide
12 each participating physician or provider, not later than the fifth
13 ~~[10th]~~ business day after the date a request is made, a list of
14 health care services that ~~[do not]~~ require preauthorization and
15 information concerning the preauthorization process.

16 SECTION 1.02. Subchapter J, Chapter 843, Insurance Code, is
17 amended by adding Sections 843.3481, 843.3482, and 843.3483 to read
18 as follows:

19 Sec. 843.3481. POSTING OF PREAUTHORIZATION REQUIREMENTS.

20 (a) A health maintenance organization that uses a preauthorization
21 process for health care services shall make the requirements and
22 information about the preauthorization process readily accessible
23 to enrollees, physicians, providers, and the general public by
24 posting the requirements and information on the health maintenance

1 organization's Internet website.

2 (b) The preauthorization requirements and information
3 described by Subsection (a) must:

4 (1) be posted:

5 (A) except as provided by Subsection (c) or (d),
6 conspicuously in a location on the Internet website that does not
7 require the use of a log-in or other input of personal information
8 to view the information; and

9 (B) in a format that is easily searchable and
10 accessible;

11 (2) except for the screening criteria under Paragraph
12 (4)(C), be written in plain language that is easily understandable
13 by enrollees, physicians, providers, and the general public;

14 (3) include a detailed description of the
15 preauthorization process and procedure; and

16 (4) include an accurate and current list of the health
17 care services for which the health maintenance organization
18 requires preauthorization that includes the following information
19 specific to each service:

20 (A) the effective date of the preauthorization
21 requirement;

22 (B) a list or description of any supporting
23 documentation that the health maintenance organization requires
24 from the physician or provider ordering or requesting the service
25 to approve a request for that service;

26 (C) the applicable screening criteria, which may
27 include Current Procedural Terminology codes and International

1 Classification of Diseases codes; and
2 (D) statistics regarding preauthorization
3 approval and denial rates for the service in the preceding year,
4 including statistics in the following categories:
5 (i) physician or provider type and
6 specialty, if any;
7 (ii) indication offered;
8 (iii) reasons for request denial;
9 (iv) denials overturned on appeal; and
10 (v) total annual preauthorization
11 requests, approvals, and denials for the service.
12 (c) This section may not be construed to require a health
13 maintenance organization to provide specific information that
14 would violate any applicable copyright law or licensing agreement.
15 A health maintenance organization is required to supply, in lieu of
16 any information withheld on the basis of copyright law or a
17 licensing agreement, a summary of the withheld information
18 sufficient to allow a licensed physician or provider, as applicable
19 for the specific service, who has sufficient training and
20 experience related to the service to understand the basis for the
21 health maintenance organization's medical necessity or
22 appropriateness determinations.
23 (d) If a requirement or information described by Subsection
24 (a) is licensed, proprietary, or copyrighted material that the
25 health maintenance organization has received from a third party
26 with which the health maintenance organization has contracted, the
27 health maintenance organization may, instead of making that

1 information publicly available on the health maintenance
2 organization's Internet website, provide the material to a
3 physician or provider who submits a preauthorization request using
4 a nonpublic secured Internet website link or other protected,
5 nonpublic electronic means.

6 Sec. 843.3482. CHANGES TO PREAUTHORIZATION REQUIREMENTS.

7 (a) Except as provided by Subsection (b), not later than the 60th
8 day before the date a new or amended preauthorization requirement
9 takes effect, a health maintenance organization that uses a
10 preauthorization process for health care services shall provide
11 notice of the new or amended preauthorization requirement in the
12 health maintenance organization's newsletter or network bulletin,
13 if any, and on the health maintenance organization's Internet
14 website.

15 (b) For a change in a preauthorization requirement or
16 process that removes a service from the list of health care services
17 requiring preauthorization or amends a preauthorization
18 requirement in a way that is less burdensome to enrollees or
19 participating physicians or providers, a health maintenance
20 organization shall provide notice of the change in the
21 preauthorization requirement in the health maintenance
22 organization's newsletter or network bulletin, if any, and on the
23 health maintenance organization's Internet website not later than
24 the fifth day before the date the change takes effect.

25 (c) Not later than the fifth day before the date a new or
26 amended preauthorization requirement takes effect, a health
27 maintenance organization shall update its Internet website to

1 disclose the change to the health maintenance organization's
2 preauthorization requirements or process and the date and time the
3 change is effective.

4 Sec. 843.3483. REMEDY FOR NONCOMPLIANCE. In addition to
5 any other penalty or remedy provided by law, a health maintenance
6 organization that uses a preauthorization process for health care
7 services that violates this subchapter with respect to a required
8 publication, notice, or response regarding its preauthorization
9 requirements, including by failing to comply with any applicable
10 deadline for the publication, notice, or response, must provide an
11 expedited appeal under Section 4201.357 for any health care service
12 affected by the violation.

13 SECTION 1.03. Section 1301.135(a), Insurance Code, is
14 amended to read as follows:

15 (a) An insurer that uses a preauthorization process for
16 medical care or ~~[and]~~ health care services shall provide to each
17 preferred provider, not later than the fifth ~~[10th]~~ business day
18 after the date a request is made, a list of medical care and health
19 care services that require preauthorization and information
20 concerning the preauthorization process.

21 SECTION 1.04. Subchapter C-1, Chapter 1301, Insurance Code,
22 is amended by adding Sections 1301.1351, 1301.1352, and 1301.1353
23 to read as follows:

24 Sec. 1301.1351. POSTING OF PREAUTHORIZATION REQUIREMENTS.

25 (a) An insurer that uses a preauthorization process for medical
26 care or health care services shall make the requirements and
27 information about the preauthorization process readily accessible

1 to insureds, physicians, health care providers, and the general
2 public by posting the requirements and information on the insurer's
3 Internet website.

4 (b) The preauthorization requirements and information
5 described by Subsection (a) must:

6 (1) be posted:

7 (A) except as provided by Subsection (c) or (d),
8 conspicuously in a location on the Internet website that does not
9 require the use of a log-in or other input of personal information
10 to view the information; and

11 (B) in a format that is easily searchable and
12 accessible;

13 (2) except for the screening criteria under Paragraph
14 (4)(C), be written in plain language that is easily understandable
15 by insureds, physicians, health care providers, and the general
16 public;

17 (3) include a detailed description of the
18 preauthorization process and procedure; and

19 (4) include an accurate and current list of medical
20 care and health care services for which the insurer requires
21 preauthorization that includes the following information specific
22 to each service:

23 (A) the effective date of the preauthorization
24 requirement;

25 (B) a list or description of any supporting
26 documentation that the insurer requires from the physician or
27 health care provider ordering or requesting the service to approve

1 a request for the service;

2 (C) the applicable screening criteria, which may
3 include Current Procedural Terminology codes and International
4 Classification of Diseases codes; and

5 (D) statistics regarding the insurer's
6 preauthorization approval and denial rates for the medical care or
7 health care service in the preceding year, including statistics in
8 the following categories:

9 (i) physician or health care provider type
10 and specialty, if any;

11 (ii) indication offered;

12 (iii) reasons for request denial;

13 (iv) denials overturned on appeal; and

14 (v) total annual preauthorization
15 requests, approvals, and denials for the service.

16 (c) This section may not be construed to require an insurer
17 to provide specific information that would violate any applicable
18 copyright law or licensing agreement. An insurer is required to
19 supply, in lieu of any information withheld on the basis of
20 copyright law or a licensing agreement, a summary of the withheld
21 information sufficient to allow a licensed physician or other
22 health care provider, as applicable for the specific service, who
23 has sufficient training and experience related to the service to
24 understand the basis for the insurer's medical necessity or
25 appropriateness determinations.

26 (d) If a requirement or information described by Subsection
27 (a) is licensed, proprietary, or copyrighted material that the

1 insurer has received from a third party with which the insurer has
2 contracted, the insurer may, instead of making that information
3 publicly available on the insurer's Internet website, provide the
4 material to a physician or health care provider who submits a
5 preauthorization request using a nonpublic secured Internet
6 website link or other protected, nonpublic electronic means.

7 (e) The provisions of this section may not be waived,
8 voided, or nullified by contract.

9 Sec. 1301.1352. CHANGES TO PREAUTHORIZATION REQUIREMENTS.

10 (a) Except as provided by Subsection (b), not later than the 60th
11 day before the date a new or amended preauthorization requirement
12 takes effect, an insurer that uses a preauthorization process for
13 medical care or health care services shall provide notice of the new
14 or amended preauthorization requirement in the insurer's
15 newsletter or network bulletin, if any, and on the insurer's
16 Internet website.

17 (b) For a change in a preauthorization requirement or
18 process that removes a service from the list of medical care or
19 health care services requiring preauthorization or amends a
20 preauthorization requirement in a way that is less burdensome to
21 insureds, physicians, or health care providers, an insurer shall
22 provide notice of the change in the preauthorization requirement in
23 the insurer's newsletter or network bulletin, if any, and on the
24 insurer's Internet website not later than the fifth day before the
25 date the change takes effect.

26 (c) Not later than the fifth day before the date a new or
27 amended preauthorization requirement takes effect, an insurer

1 shall update its Internet website to disclose the change to the
2 insurer's preauthorization requirements or process and the date and
3 time the change is effective.

4 (d) The provisions of this section may not be waived,
5 voided, or nullified by contract.

6 Sec. 1301.1353. REMEDY FOR NONCOMPLIANCE. (a) In addition
7 to any other penalty or remedy provided by law, an insurer that uses
8 a preauthorization process for medical care or health care services
9 that violates this subchapter with respect to a required
10 publication, notice, or response regarding its preauthorization
11 requirements, including by failing to comply with any applicable
12 deadline for the publication, notice, or response, must provide an
13 expedited appeal under Section 4201.357 for any medical care or
14 health care service affected by the violation.

15 (b) The provisions of this section may not be waived,
16 voided, or nullified by contract.

17 ARTICLE 2. UTILIZATION, INDEPENDENT, AND PEER REVIEW

18 SECTION 2.01. Section 4201.002(12), Insurance Code, is
19 amended to read as follows:

20 (12) "Provider of record" means the physician or other
21 health care provider with primary responsibility for the health
22 care[, ~~treatment, and~~ services provided to or requested on behalf
23 of an enrollee or the physician or other health care provider that
24 has provided or has been requested to provide the health care
25 services to the enrollee. The term includes a health care facility
26 where the health care services are [~~if treatment is~~] provided on an
27 inpatient or outpatient basis.

1 SECTION 2.02. Sections 4201.151 and 4201.152, Insurance
2 Code, are amended to read as follows:

3 Sec. 4201.151. UTILIZATION REVIEW PLAN. A utilization
4 review agent's utilization review plan, including reconsideration
5 and appeal requirements, must be reviewed by a physician licensed
6 to practice medicine in this state and conducted in accordance with
7 standards developed with input from appropriate health care
8 providers and approved by a physician licensed to practice medicine
9 in this state.

10 Sec. 4201.152. UTILIZATION REVIEW UNDER [~~DIRECTION OF~~]
11 PHYSICIAN. A utilization review agent shall conduct utilization
12 review under the direction of a physician licensed to practice
13 medicine in this [~~by a~~] state [~~licensing agency in the United~~
14 ~~States~~].

15 SECTION 2.03. Section 4201.153(d), Insurance Code, is
16 amended to read as follows:

17 (d) Screening criteria must be used to determine only
18 whether to approve the requested treatment. Before issuing an
19 adverse determination, a utilization review agent must obtain a
20 determination of medical necessity and appropriateness by
21 referring a proposed [A] denial of requested treatment [~~must be~~
22 ~~referred~~] to:

23 (1) an appropriate physician, dentist, or other health
24 care provider; or

25 (2) if the treatment is requested, ordered, provided,
26 or to be provided by a physician, a physician licensed to practice
27 medicine who is of the same or a similar specialty as that physician

1 ~~[to determine medical necessity]~~.

2 SECTION 2.04. Sections 4201.155, 4201.206, and 4201.251,
3 Insurance Code, are amended to read as follows:

4 Sec. 4201.155. LIMITATION ON NOTICE REQUIREMENTS AND REVIEW
5 PROCEDURES. (a) A utilization review agent may not establish or
6 impose a notice requirement or other review procedure that is
7 contrary to the requirements of the health insurance policy or
8 health benefit plan.

9 (b) This section may not be construed to release a health
10 insurance policy or health benefit plan from full compliance with
11 this chapter or other applicable law.

12 Sec. 4201.206. OPPORTUNITY TO DISCUSS TREATMENT BEFORE
13 ADVERSE DETERMINATION. (a) Subject to Subsection (b) and the
14 notice requirements of Subchapter G, before an adverse
15 determination is issued by a utilization review agent who questions
16 the medical necessity, the ~~[or]~~ appropriateness, or the
17 experimental or investigational nature~~[r]~~ of a health care service,
18 the agent shall provide the health care provider who ordered,
19 requested, provided, or is to provide the service a reasonable
20 opportunity to discuss with a physician licensed to practice
21 medicine the patient's treatment plan and the clinical basis for
22 the agent's determination.

23 (b) If the health care service described by Subsection (a)
24 was ordered, requested, or provided, or is to be provided by a
25 physician, the opportunity described by that subsection must be
26 with a physician licensed to practice medicine who is of the same or
27 a similar specialty as that physician.

1 Sec. 4201.251. DELEGATION OF UTILIZATION REVIEW. A
2 utilization review agent may delegate utilization review to
3 qualified personnel in the hospital or other health care facility
4 in which the health care services to be reviewed were or are to be
5 provided. The delegation does not release the agent from the full
6 responsibility for compliance with this chapter or other applicable
7 law, including the conduct of those to whom utilization review has
8 been delegated.

9 SECTION 2.05. Sections 4201.252(a) and (b), Insurance Code,
10 are amended to read as follows:

11 (a) Personnel employed by or under contract with a
12 utilization review agent to perform utilization review must be
13 appropriately trained and qualified and meet the requirements of
14 this chapter and other applicable law, including applicable
15 licensing requirements.

16 (b) Personnel, other than a physician licensed to practice
17 medicine, who obtain oral or written information directly from a
18 patient's physician or other health care provider regarding the
19 patient's specific medical condition, diagnosis, or treatment
20 options or protocols must be a nurse, physician assistant, or other
21 health care provider qualified and licensed or otherwise authorized
22 by law and an appropriate licensing agency in the United States to
23 provide the requested service.

24 SECTION 2.06. Section 4201.356, Insurance Code, is amended
25 to read as follows:

26 Sec. 4201.356. DECISION BY PHYSICIAN REQUIRED; SPECIALTY
27 REVIEW. (a) The procedures for appealing an adverse determination

1 must provide that a physician licensed to practice medicine makes
2 the decision on the appeal, except as provided by Subsection (b).

3 (b) If not later than the 10th working day after the date an
4 appeal is requested or denied the enrollee's health care provider
5 requests [~~states in writing good cause for having~~] a particular
6 type of specialty provider review the case, a health care provider
7 who is of the same or a similar specialty as the health care
8 provider who would typically manage the medical or dental
9 condition, procedure, or treatment under consideration for review
10 and who is licensed or otherwise authorized by the appropriate
11 licensing agency in the United States to manage the medical or
12 dental condition, procedure, or treatment shall review the denial
13 or the decision denying the appeal. The specialty review must be
14 completed within 15 working days of the date the health care
15 provider's request for specialty review is received.

16 SECTION 2.07. Sections 4201.357(a), (a-1), and (a-2),
17 Insurance Code, are amended to read as follows:

18 (a) The procedures for appealing an adverse determination
19 must include, in addition to the written appeal, a procedure for an
20 expedited appeal of a denial of emergency care, [or] a denial of
21 continued hospitalization, or a denial of another service if the
22 requesting health care provider includes a written statement with
23 supporting documentation that the service is necessary to treat a
24 life-threatening condition or prevent serious harm to the patient.

25 That procedure must include a review by a health care provider who:

26 (1) has not previously reviewed the case; [~~and~~]

27 (2) is of the same or a similar specialty as the health

1 care provider who would typically manage the medical or dental
2 condition, procedure, or treatment under review in the appeal; and

3 (3) for a review of a health care service:

4 (A) ordered, requested, or to be provided by a
5 health care provider who is not a physician, is licensed or
6 otherwise authorized by an appropriate licensing agency in the
7 United States; or

8 (B) ordered, requested, or to be provided by a
9 physician, is licensed to practice medicine in the United States.

10 (a-1) The procedures for appealing an adverse determination
11 must include, in addition to the written appeal and the appeal
12 described by Subsection (a), a procedure for an expedited appeal of
13 a denial of prescription drugs or intravenous infusions for which
14 the patient is receiving benefits under the health insurance
15 policy. That procedure must include a review by a health care
16 provider who:

17 (1) has not previously reviewed the case; ~~[and]~~

18 (2) is of the same or a similar specialty as the health
19 care provider who would typically manage the medical or dental
20 condition, procedure, or treatment under review in the appeal; and

21 (3) for a review of a health care service:

22 (A) ordered, requested, or to be provided by a
23 health care provider who is not a physician, is licensed or
24 otherwise authorized by the appropriate licensing agency in this
25 state to provide the service in this state; or

26 (B) ordered, requested, or to be provided by a
27 physician, is licensed to practice medicine in this state.

1 (a-2) An adverse determination under Section 1369.0546 is
2 entitled to an expedited appeal. The physician or, if appropriate,
3 other health care provider deciding the appeal must consider
4 atypical diagnoses and the needs of atypical patient populations.
5 The physician must be licensed to practice medicine in the United
6 States and the health care provider must be licensed or otherwise
7 authorized by an appropriate licensing agency in the United States.

8 SECTION 2.08. Section 4201.359, Insurance Code, is amended
9 by adding Subsection (c) to read as follows:

10 (c) A physician described by Subsection (b)(2) must comply
11 with this chapter and other applicable laws and be licensed to
12 practice medicine. A health care provider described by Subsection
13 (b)(2) must comply with this chapter and other applicable laws and
14 be licensed or otherwise authorized by an appropriate licensing
15 agency in the United States.

16 SECTION 2.09. Sections 4201.453 and 4201.454, Insurance
17 Code, are amended to read as follows:

18 Sec. 4201.453. UTILIZATION REVIEW PLAN. A specialty
19 utilization review agent's utilization review plan, including
20 reconsideration and appeal requirements, must be:

21 (1) reviewed by a health care provider of the
22 appropriate specialty who is licensed or otherwise authorized to
23 provide the specialty health care service in this state; and

24 (2) conducted in accordance with standards developed
25 with input from a health care provider of the appropriate specialty
26 who is licensed or otherwise authorized to provide the specialty
27 health care service in this state.

1 Sec. 4201.454. UTILIZATION REVIEW UNDER DIRECTION OF
2 PROVIDER OF SAME SPECIALTY. A specialty utilization review agent
3 shall conduct utilization review under the direction of a health
4 care provider who is of the same specialty as the agent and who is
5 licensed or otherwise authorized to provide the specialty health
6 care service in this ~~[by a]~~ state ~~[licensing agency in the United~~
7 ~~States]~~.

8 SECTION 2.10. Sections 4201.455(a) and (b), Insurance Code,
9 are amended to read as follows:

10 (a) Personnel who are employed by or under contract with a
11 specialty utilization review agent to perform utilization review
12 must be appropriately trained and qualified and meet the
13 requirements of this chapter and other applicable law of this
14 state, including applicable licensing laws.

15 (b) Personnel who obtain oral or written information
16 directly from a physician or other health care provider must be a
17 nurse, physician assistant, or other health care provider of the
18 same specialty as the agent and who are licensed or otherwise
19 authorized to provide the specialty health care service by a
20 ~~[state]~~ licensing agency in the United States.

21 SECTION 2.11. Sections 4201.456 and 4201.457, Insurance
22 Code, are amended to read as follows:

23 Sec. 4201.456. OPPORTUNITY TO DISCUSS TREATMENT BEFORE
24 ADVERSE DETERMINATION. Subject to the notice requirements of
25 Subchapter G, before an adverse determination is issued by a
26 specialty utilization review agent who questions the medical
27 necessity, the ~~[or]~~ appropriateness, or the experimental or

1 investigational nature[7] of a health care service, the agent shall
2 provide the health care provider who ordered, requested, or is to
3 provide the service a reasonable opportunity to discuss the
4 patient's treatment plan and the clinical basis for the agent's
5 determination with a health care provider who is:

- 6 (1) of the same specialty as the agent; and
7 (2) licensed or otherwise authorized to provide the
8 specialty health care service by a licensing agency in the United
9 States.

10 Sec. 4201.457. APPEAL DECISIONS. A specialty utilization
11 review agent shall comply with the requirement that a physician or
12 other health care provider who makes the decision in an appeal of an
13 adverse determination must be:

- 14 (1) of the same or a similar specialty as the health
15 care provider who would typically manage the specialty condition,
16 procedure, or treatment under review in the appeal; and
17 (2) licensed or otherwise authorized to provide the
18 health care service by a licensing agency in the United States.

19 SECTION 2.12. Section 408.0043, Labor Code, is amended by
20 adding Subsection (c) to read as follows:

- 21 (c) Notwithstanding Subsection (b), if a health care
22 service is requested, ordered, provided, or to be provided by a
23 physician, a person described by Subsection (a)(1), (2), or (3) who
24 reviews the service with respect to a specific workers'
25 compensation case must be of the same or a similar specialty as that
26 physician.

27 SECTION 2.13. Section 1305.351(d), Insurance Code, is

1 amended to read as follows:

2 (d) A [~~Notwithstanding Section 4201.152, a~~] utilization
3 review agent or an insurance carrier that uses doctors to perform
4 reviews of health care services provided under this chapter,
5 including utilization review, or peer reviews under Section
6 408.0231(g), Labor Code, may only use doctors licensed to practice
7 in this state.

8 SECTION 2.14. Section 1305.355(d), Insurance Code, is
9 amended to read as follows:

10 (d) The department shall assign the review request to an
11 independent review organization. An [~~Notwithstanding Section~~
12 ~~4202.002, an~~] independent review organization that uses doctors to
13 perform reviews of health care services under this chapter may only
14 use doctors licensed to practice in this state.

15 SECTION 2.15. Section 408.023(h), Labor Code, is amended to
16 read as follows:

17 (h) A [~~Notwithstanding Section 4201.152, Insurance Code, a~~]
18 utilization review agent or an insurance carrier that uses doctors
19 to perform reviews of health care services provided under this
20 subtitle, including utilization review, may only use doctors
21 licensed to practice in this state.

22 SECTION 2.16. Section 413.031(e-2), Labor Code, is amended
23 to read as follows:

24 (e-2) An [~~Notwithstanding Section 4202.002, Insurance Code,~~
25 ~~an~~] independent review organization that uses doctors to perform
26 reviews of health care services provided under this title may only
27 use doctors licensed to practice in this state.

1 ARTICLE 3. JOINT INTERIM STUDY

2 SECTION 3.01. CREATION OF JOINT INTERIM COMMITTEE. (a) A
3 joint interim committee is created to study, review, and report on
4 the use of prior authorization and utilization review processes by
5 private health benefit plan issuers in this state, as provided by
6 Section 3.02 of this article, and propose reforms under that
7 section related to the transparency of and improving patient
8 outcomes under the prior authorization and utilization review
9 processes used by private health benefit plan issuers in this
10 state.

11 (b) The joint interim committee shall be composed of four
12 senators appointed by the lieutenant governor and four members of
13 the house of representatives appointed by the speaker of the house
14 of representatives.

15 (c) The lieutenant governor and speaker of the house of
16 representatives shall each designate a co-chair from among the
17 joint interim committee members.

18 (d) The joint interim committee shall convene at the joint
19 call of the co-chairs.

20 (e) The joint interim committee has all other powers and
21 duties provided to a special or select committee by the rules of the
22 senate and house of representatives, by Subchapter B, Chapter 301,
23 Government Code, and by policies of the senate and house committees
24 on administration.

25 SECTION 3.02. INTERIM STUDY REGARDING PRIOR AUTHORIZATION
26 AND UTILIZATION REVIEW PROCESSES. (a) The joint interim committee
27 created by Section 3.01 of this article shall study data and other

1 information available from the Texas Department of Insurance, the
2 office of public insurance counsel, or other sources the committee
3 determines relevant to examine and analyze the transparency of and
4 improving patient outcomes under the prior authorization and
5 utilization review processes used by private health benefit plan
6 issuers in this state.

7 (b) The joint interim committee shall propose reforms based
8 on the study required under Subsection (a) of this section to
9 improve the transparency of and patient outcomes under prior
10 authorization and utilization review processes in this state.

11 (c) The joint interim committee shall prepare a report of
12 the findings and proposed reforms.

13 SECTION 3.03. COMMITTEE FINDINGS AND PROPOSED REFORMS. (a)
14 Not later than December 1, 2020, the joint interim committee
15 created under Section 3.01 of this article shall submit to the
16 lieutenant governor, the speaker of the house of representatives,
17 and the governor the report prepared under Section 3.02 of this
18 article. The joint interim committee shall include in its report
19 recommendations of specific statutory and regulatory changes that
20 appear necessary from the committee's study under Section 3.02 of
21 this article.

22 (b) Not later than the 60th day after the effective date of
23 this Act, the lieutenant governor and speaker of the house of
24 representatives shall appoint the members of the joint interim
25 committee in accordance with Section 3.01 of this article.

26 SECTION 3.04. ABOLITION OF COMMITTEE. The joint interim
27 committee created under Section 3.01 of this article is abolished

1 and this article expires December 15, 2020.

2 ARTICLE 4. TRANSITIONS; EFFECTIVE DATE

3 SECTION 4.01. The changes in law made by Article 1 of this
4 Act apply only to a request for preauthorization of medical care or
5 health care services made on or after January 1, 2020, under a
6 health benefit plan delivered, issued for delivery, or renewed on
7 or after that date. A request for preauthorization of medical care
8 or health care services made before January 1, 2020, or on or after
9 January 1, 2020, under a health benefit plan delivered, issued for
10 delivery, or renewed before that date is governed by the law as it
11 existed immediately before the effective date of this Act, and that
12 law is continued in effect for that purpose.

13 SECTION 4.02. The changes in law made by Article 2 of this
14 Act apply only to utilization, independent, or peer review
15 requested on or after the effective date of this Act. Utilization,
16 independent, or peer review requested before the effective date of
17 this Act is governed by the law as it existed immediately before the
18 effective date of this Act, and that law is continued in effect for
19 that purpose.

20 SECTION 4.03. This Act takes effect September 1, 2019.

ADOPTED

MAY 22 2019

FLOOR AMENDMENT NO. 1

Letai Spaw
Secretary of the Senate

BY

D. Bucking

1 Amend C.S.H.B. No. 2327 (senate committee printing) as
2 follows:

3 (1) In SECTION 1.02 of the bill, in added Section
4 843.3481(b)(4)(D), Insurance Code (page 2, line 14), between
5 "preceding" and "year", insert "calendar".

6 (2) In SECTION 1.02 of the bill, in added Section 843.3481(c),
7 Insurance Code (page 2, lines 26-28), strike "is required to
8 supply, in lieu of any information withheld on the basis of
9 copyright law or a licensing agreement," and substitute "may,
10 instead of making that information publicly available on the health
11 maintenance organization's Internet website, supply".

12 (3) In SECTION 1.04 of the bill, in added Section
13 1301.1351(b)(4)(D), Insurance Code (page 3, line 57), between
14 "preceding" and "year", insert "calendar".

15 (4) In SECTION 1.04 of the bill, in added Section
16 1301.1351(c), Insurance Code (page 3, line 68, through page 4,
17 line 1), strike "is required to supply, in lieu of any information
18 withheld on the basis of copyright law or a licensing agreement,"
19 and substitute "may, instead of making that information publicly
20 available on the insurer's Internet website, supply".

21 (5) In SECTION 2.03 of the bill, strike amended Section
22 4201.153(d), Insurance Code (page 5, lines 10-21), and substitute
23 the following:

24 (d) Screening criteria must be used to determine only
25 whether to approve the requested treatment. Before issuing an
26 adverse determination, a utilization review agent must obtain a
27 determination of medical necessity and appropriateness by
28 referring a proposed [A] denial of requested treatment [~~must be~~
29 ~~referred~~] to an appropriate physician, dentist, or other health

1 care provider [~~to determine medical necessity~~].

2 (6) In SECTION 2.04 of the bill, in added Section 4201.206(b),
3 Insurance Code (page 5, lines 46-47), strike "who is of the same
4 or a similar specialty as that physician".

5 (7) In SECTION 2.07 of the bill, in added Section 4201.357(a-
6 1)(3)(A), Insurance Code (page 6, lines 56-57), strike "in this
7 state to provide the service in this state" and substitute "in the
8 United States".

9 (8) In SECTION 2.07 of the bill, in added Section 4201.357(a-
10 1)(3)(B), Insurance Code (page 6, line 59), strike "in this state"
11 and substitute "in the United States".

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 86TH LEGISLATIVE REGULAR SESSION

May 23, 2019

TO: Honorable Dennis Bonnen, Speaker of the House, House of Representatives

FROM: John McGeady, Assistant Director Sarah Keyton, Assistant Director
Legislative Budget Board

IN RE: HB2327 by Bonnen, Greg (Relating to preauthorization of certain medical care and health care services by certain health benefit plan issuers and to the regulation of utilization review, independent review, and peer review for health benefit plan and workers' compensation coverage.), **As Passed 2nd House**

No significant fiscal implication to the State is anticipated.

This bill would amend the Insurance Code and Labor Code relating to preauthorization of certain medical care and health care services by certain health benefit plan issuers and to the regulation of utilization review, independent review, and peer review for health benefit plan and workers' compensation coverage.

Based on information provided by the Texas Department of Insurance, Employees Retirement System, State Office of Risk Management, Texas Department of Transportation, The University of Texas System Administration, and Texas A&M University System Administration, this analysis assumes that the duties and responsibilities associated with implementing the provisions of the bill could be accomplished by utilizing existing resources.

According to the Health and Human Services Commission (HHSC), federal rule addresses preauthorization requirements for managed care organizations that contract to provide for Medicaid and Children's Health Insurance Program (CHIP) services; therefore, it is assumed these provisions would not apply to Medicaid or CHIP and there would be no fiscal impact to HHSC. If the provisions were applied to those programs, HHSC may need to increase managed care premiums to account for the additional administrative burden, which would result in a cost that could be significant.

The bill applies only to a request for preauthorization of medical care or health care services made on or after January 1, 2020. The bill applies only to utilization, independent, or peer review that was requested on or after the effective date of the bill. The bill would take effect on September 1, 2019.

Local Government Impact

No fiscal implication to units of local government is anticipated.

Source Agencies: 327 Employees Retirement System, 454 Department of Insurance, 479 State Office of Risk Management, 529 Health and Human Services Commission

LBB Staff: WP, CLo, CP

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 86TH LEGISLATIVE REGULAR SESSION

May 20, 2019

TO: Honorable Kelly Hancock, Chair, Senate Committee on Business & Commerce

FROM: John McGeady, Assistant Director Sarah Keyton, Assistant Director
Legislative Budget Board

IN RE: HB2327 by Bonnen, Greg (Relating to preauthorization of certain medical care and health care services by certain health benefit plan issuers and to the regulation of utilization review, independent review, and peer review for health benefit plan and workers' compensation coverage.), **Committee Report 2nd House, Substituted**

No significant fiscal implication to the State is anticipated.

This bill would amend the Insurance Code and Labor Code relating to preauthorization of certain medical care and health care services by certain health benefit plan issuers and to the regulation of utilization review, independent review, and peer review for health benefit plan and workers' compensation coverage.

Based on information provided by the Texas Department of Insurance, Employees Retirement System, State Office of Risk Management, Texas Department of Transportation, The University of Texas System Administration, and Texas A&M University System Administration, this analysis assumes that the duties and responsibilities associated with implementing the provisions of the bill could be accomplished by utilizing existing resources.

According to the Health and Human Services Commission (HHSC), federal rule addresses preauthorization requirements for managed care organizations that contract to provide for Medicaid and Children's Health Insurance Program (CHIP) services; therefore, it is assumed these provisions would not apply to Medicaid or CHIP and there would be no fiscal impact to HHSC. If the provisions were applied to those programs, HHSC may need to increase managed care premiums to account for the additional administrative burden, which would result in a cost that could be significant.

The bill applies only to a request for preauthorization of medical care or health care services made on or after January 1, 2020. The bill applies only to utilization, independent, or peer review that was requested on or after the effective date of the bill. The bill would take effect on September 1, 2019.

Local Government Impact

No fiscal implication to units of local government is anticipated.

Source Agencies: 327 Employees Retirement System, 454 Department of Insurance, 479 State Office of Risk Management, 529 Health and Human Services Commission

LBB Staff: WP, CLo, CP

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 86TH LEGISLATIVE REGULAR SESSION

May 3, 2019

TO: Honorable Kelly Hancock, Chair, Senate Committee on Business & Commerce

FROM: John McGeady, Assistant Director Sarah Keyton, Assistant Director
Legislative Budget Board

IN RE: HB2327 by Bonnen, Greg (Relating to preauthorization of certain medical care and health care services by certain health benefit plan issuers and to the regulation of utilization review, independent review, and peer review for health benefit plan and workers' compensation coverage.), **As Engrossed**

The fiscal implications of the bill cannot be determined at this time due to the inability to determine potential increased workers' compensation plan costs to the State Office of Risk Management (SORM) and state agencies.

This bill would amend the Insurance Code, Labor Code, and Occupations Code relating to preauthorization of certain medical care and health care services by certain health benefit plan issuers and to the regulation of utilization review, independent review, and peer review for health benefit plan and workers' compensation coverage.

SORM anticipates increased administrative costs and increased costs to state agencies relating to workers' compensation under the provisions of the bill. The fiscal implications of the bill cannot be determined at this time due to the inability to determine potential increased costs to SORM and state agencies. The bill would potentially increase the cost for contracted preauthorization review, reduce the number of contractors and physicians available for reviews, and increase the number of services preauthorized on first request, resulting in potential increased costs paid for medical services. Potential costs may be offset by fewer initial denials, resulting in decreased administrative costs.

Based on information provided by the Texas Department of Insurance, Employees Retirement System, Texas Medical Board, Texas Department of Transportation, The University of Texas System Administration, and Texas A&M University System Administration, this analysis assumes that the duties and responsibilities associated with implementing the provisions of the bill could be accomplished by utilizing existing resources.

According to the Health and Human Services Commission (HHSC), federal rule addresses preauthorization requirements for managed care organizations that contract to provide for Medicaid and Children's Health Insurance Program (CHIP) services; therefore, it is assumed these provisions would not apply to Medicaid or CHIP and there would be no fiscal impact to HHSC. If the provisions were applied to those programs, HHSC may need to increase managed care premiums to account for the additional administrative burden, which would result in a cost that could be significant.

The bill applies only to a request for preauthorization of medical care or health care services made on or after January 1, 2020. The bill applies only to utilization, independent, or peer review requested on or after the effective date of the bill. The bill would take effect on September 1, 2019.

Local Government Impact

No significant fiscal implication to units of local government is anticipated.

Source Agencies: 327 Employees Retirement System, 454 Department of Insurance, 479 State Office of Risk Management, 503 Texas Medical Board, 529 Health and Human Services Commission, 601 Department of Transportation, 710 Texas A&M University System Administrative and General Offices, 720 The University of Texas System Administration

LBB Staff: WP, CLo, SGr, CP, AF, LR, CMa, DFR

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 86TH LEGISLATIVE REGULAR SESSION

April 9, 2019

TO: Honorable Eddie Lucio III, Chair, House Committee on Insurance

FROM: John McGeady, Assistant Director Sarah Keyton, Assistant Director
Legislative Budget Board

IN RE: HB2327 by Bonnen, Greg (relating to preauthorization of certain medical care and health care services by certain health benefit plan issuers.), **Committee Report 1st House, Substituted**

No significant fiscal implication to the State is anticipated.

This bill would amend the Insurance Code relating to preauthorization of certain medical care and health care services by certain health benefit plan issuers. Based on information provided by the Texas Department of Insurance and Employees Retirement System, this analysis assumes that the duties and responsibilities associated with implementing the provisions of the bill could be accomplished by utilizing existing resources.

According to the Health and Human Services Commission (HHSC), federal rule addresses preauthorization requirements for managed care organizations that contract to provide for Medicaid and Children's Health Insurance Program (CHIP) services; therefore, it is assumed these provisions would not apply to Medicaid or CHIP and there would be no fiscal impact to HHSC. If the provisions were applied to those programs, HHSC may need to increase managed care premiums to account for the additional administrative burden, which would result in a cost that could be significant.

The bill applies only to a request for preauthorization of medical care or health care services made on or after January 1, 2020. The bill would take effect on September 1, 2019.

Local Government Impact

No fiscal implication to units of local government is anticipated.

Source Agencies: 327 Employees Retirement System, 454 Department of Insurance, 529 Health and Human Services Commission, 710 Texas A&M University System Administrative and General Offices, 720 The University of Texas System Administration

LBB Staff: WP, LR, CMa, SGr, CP, DFR

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 86TH LEGISLATIVE REGULAR SESSION

March 25, 2019

TO: Honorable Eddie Lucio III, Chair, House Committee on Insurance

FROM: John McGeady, Assistant Director Sarah Keyton, Assistant Director
Legislative Budget Board

IN RE: HB2327 by Bonnen, Greg (Relating to preauthorization of certain medical care and health care services by certain health benefit plan issuers.), **As Introduced**

No significant fiscal implication to the State is anticipated.

This bill would amend the Insurance Code relating to preauthorization of certain medical care and health care services by certain health benefit plan issuers. Based on information provided by the Texas Department of Insurance and Employees Retirement System, this analysis assumes that the duties and responsibilities associated with implementing the provisions of the bill could be accomplished by utilizing existing resources.

According to the Health and Human Services Commission (HHSC), federal rule addresses preauthorization requirements for managed care organizations that contract to provide for Medicaid and Children's Health Insurance Program (CHIP) services; therefore, it is assumed these provisions would not apply to Medicaid or CHIP and there would be no fiscal impact to HHSC. If the provisions were applied to those programs, HHSC may need to increase managed care premiums to account for the additional administrative burden, which would result in a cost that could be significant.

The bill applies only to a request for preauthorization of medical care or health care services made on or after September 1, 2019. The bill would take effect on September 1, 2019.

Local Government Impact

No fiscal implication to units of local government is anticipated.

Source Agencies: 327 Employees Retirement System, 454 Department of Insurance, 529 Health and Human Services Commission, 710 Texas A&M University System Administrative and General Offices, 720 The University of Texas System Administration

LBB Staff: WP, CMa, SGr, CP, LR, DFR